School-Based Health Center Registration/Enrollment Form

Massachusetts Department of Public Health

FOR SBHC OFFICE USE ONLY
Medical Record Number _____ School Name_____

Registration Date
(Enrollment Period Start Date) Month ☐☐ Day ☐☐ Year ☐☐☐☐

Client Information

First Name	**Middle Name**	**Last Name**	**Suffix**

Date of Birth Month ☐☐ Day ☐☐ Year ☐☐☐☐ **Gender** Male □ Female □ Transgender □

Social Security Number ☐☐☐-☐☐-☐☐☐☐ Do not select refused or unknown, enter 999-99-9999

Home Address	Address Line 1		
	Address Line 2 (Optional)		
	City	State	Postal Code
	Primary Address? Yes □ No □		
Home Phone	(☐☐☐) ☐☐☐-☐☐☐☐		
Cell Phone	(☐☐☐) ☐☐☐-☐☐☐☐		

Demographics: Cultural Background

Are you Spanish/Hispanic/Latino? Yes □ No □

If 'yes,' please select one from the following:

___ Central American	___ Mexican, Mexican American, Chicano	___ South American
___ Cuban	___ Puerto Rican	___ Other (Specify)_____
___ Dominican	___ Salvadoran	___ Unknown

If 'no,' please select one from the following:

___ African	___ Cape Verdean	___ Haitian	___ Portuguese
___ African American	___ Caribbean Islander	___ Japanese	___ Russian
___ American	___ Chinese	___ Korean	___ Thai
___ Asian Indian	___ Eastern European	___ Laotian	___ Vietnamese
___ Brazilian	___ European	___ Latin American Indian	___ Other (Specify)_____
___ Cambodian	___ Filipino	___ Middle Eastern	___ Unknown

What is your race? (***choose all that apply)***

_____ American Indian/Alaska Native	_____ Native Hawaiian or Pacific Islander	_____ Unknown
_____ Asian	_____ White	_____ Refused
_____ Black or African American	_____ Other (Specify)_____	

In what language do you prefer to read or discuss health related materials?

_____ American Sign Language	_____ Haitian Creole	_____ Portuguese
_____ Cambodian (Khmer)	_____ Hmong	_____ Russian
_____ Cape Verdean Creole	_____ Korean	_____ Spanish
_____ Chinese	_____ Laotian	_____ Vietnamese
_____ English	_____ Other	

Insurance Information

Insurance Type	MC (PCC Program/MassHealth) □ Private Insurance □ Medicaid HMO (MassHealth) □ Other Sources □ Uninsured □						
Insurance Name	□	Aetna_US_Healthcare	□	Fallon_Community _Health_Plan	□	MassHealth – **Children's Medical Security Plan**	□ Prudential
	□	Blue_Cross/ Blue_Shield_of_MA	□	Harvard_Pilgrim	□	MassHealth – **CommonHealth**	□ Tufts_Aff_Health_ Plan
	□	Champus_**Tricare**	□	John_Hancock	□	Neighborhood_Health_Plan	□ United_Health_NE
	□	Cigna_Health	□	MassHealth	□	Other (Specify)	

Enrollment Assessment

1. If you are uninsured, have you applied for MassHealth/Medicaid? Yes □ No □ Unknown □

2. Is a <u>Consent Form</u> on file? Yes □ No □ **Note: A consent form is required for program enrollment.**

3. Do you have dental insurance? Yes □ No □ Unknown □

4. Are you a student? Yes □ No □

If yes, please select from below.

□	Pre-School/Pre-K	□	2nd Grade	□	5th Grade	□	8th Grade	□	11th Grade
□	Kindergarten	□	3rd Grade	□	6th Grade	□	9th Grade	□	12th Grade
□	1st Grade	□	4th Grade	□	7th Grade	□	10th Grade	□	Unknown

If no, please indicate how you became a client of this school clinic.

□	Graduate of School	□	Child of Student	□	Relative of Student	□	Community Member	□	School Staff

5. Do you receive additional special education services? Yes □ No □ Unknown □

6. Do you receive free or reduced-cost school lunches? Yes □ No □ Unknown □

7. In the last 12 months, did you go to see a Doctor, Nurse Practitioner, or Physician Assistant for a complete physical exam?	Yes □ No □ Unknown □
If you did see a Doctor, Nurse Practitioner, or Physician Assistant in last 12 months, what was his/her name?	PCP Name: **FOR SBHC OFFICE USE ONLY**

8. In the last 12 months, where did you go most often for healthcare?

□	Office, clinic or community health center	□	Hospital ER	□	Didn't go for care
□	School-based health center	□	Don't Know	□	Other (specify)

9. In the last 12 months, did you receive a comprehensive dental exam? Yes □ No □ Unknown □